ACKNOWLEDGEMENT OF RECEIPT AND GENERAL CONSENT FOR HIPAA POLICIES

I acknowledge that I have reviewed a copy of Dr. Wynne and Dr. Fouquet's Notice of Privacy Practices.

I further consent to the release of my health information for purposes of treatment, payment and health care operations and as authorized or required by law under the circumstances described in the Notice of Privacy Practices.

Patient Name (print clearly)_____

Signature _____ Date _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____ Print Name _____

Source of Authority _____